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Optimising HIV programming for transgender women in Brazil

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ABSTRACT

In Brazil, little data is available to inform HIV prevention programming for *travestis* and transgender ('trans') women, despite the existence of a social movement that has gained strength in recent years. We conducted formative research in Rio de Janeiro to gather trans women's perspectives on combination HIV prevention approaches. Framing the analysis within the model of gender affirmation, we found that several social and contextual factors inhibited participants' access to HIV prevention and treatment. Experienced and anticipated gender-related discrimination and HIV stigma were linked to the avoidance of HIV testing, health services and HIV status disclosure. Participants recommended HIV prevention interventions which combined socio-structural interventions, such as peer-based empowerment and social support, with biomedical interventions such as pre-exposure prophylaxis (PrEP). Participants expressed a preference for programmes and interventions that emphasised a gender-affirmative approach, promoted autonomy and aimed to reduce stigma and discrimination in public health services.

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Introduction

Globally, transgender ('trans') women[1] have 49 times higher odds of HIV infection compared to other groups, a disparity that exists across cultures and socioeconomic boundaries (Baral et al. 2013). Furthermore, HIV testing, engagement in care and adherence to medication among trans women is significantly lower than other at-risk groups (Sevelius, Carrico and Johnson 2010; Melendez and Pinto 2007). Trans women living with HIV in the USA are estimated to have the lowest proportion of viral suppression of any behavioural risk group (Los Angeles County Commission on HIV 2013; Remien et al. 2015). In South America, HIV prevalence estimates among trans women are over 30% (Dos Ramos Farias et al. 2011; Silva-Santisteban et al.

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2011), which is markedly higher than other key populations such as men who have sex with men.

A recent study in Rio de Janeiro (Grinsztejn et al. 2017) found that 31% of trans women recruited through respondent-driven sampling were HIV-positive and 7% of those were new diagnoses; furthermore, almost one-third (29%) of their participants had never been previously tested (Grinsztejn et al. 2017). Additional data corroborate that trans women are the 'most-at-risk' group in Brazil (De Boni, Veloso and Grinsztejn 2014), with estimated odds of HIV infection among trans women over 55 times higher than the general Brazilian population (Costa et al. 2015), placing Brazil among countries with the greatest HIV disparities (Baral et al. 2013). Brazilian trans women are also disproportionately at risk for experiencing violence. The estimated life expectancy of trans women is just 35, as opposed to 75 for cisgender (non-trans) women; this discrepancy is largely attributable to high murder rates of trans women in Brazil (Antunes 2010). Further, between 2008 and 2015, 802 transgender people were murdered in Brazil, the highest reported number in the world (Cazarré 2015).

Addressing transphobia (i.e. negative societal attitudes towards transgender persons) as a barrier to HIV care and prevention is vital to improving health outcomes among trans women living with or at risk of acquiring HIV in Brazil. Trans women face a complex array of psychosocial challenges that complicate their access and adherence to HIV care and prevention, such as limited access to and avoidance of health care due to stigma and past negative experiences with service providers, prioritisation of gender-related health care (e.g. hormone therapy and gender confirmation surgery) and concerns about adverse interactions between antiretroviral medications and hormone therapy (Sevelius et al. 2013). Social and economic marginalisation due to transphobia often results in poverty and unstable housing, family alienation, limited formal education, limited social support, mental illness, trauma and victimisation, substance abuse and introduction to sex work often at an early age (Nuttbrock et al. 2012; Brennan et al. 2012; Bockting et al. 2013; Nemoto, Bödeker and Iwamoto 2011; Infante, Sosa-Rubi and Cuadra 2009). These factors can result in late or no presentation to HIV medical care and poor health outcomes (Rebchook et al. 2017).

Increasing levels of critique have been expressed in the public health literature of the once common practice of subsuming trans women within the behavioural risk category of men who have sex with men (Kaplan, Sevelius and Ribeiro 2016; Minor Peters 2016). As research illuminates the unique social contexts and needs of trans women in the context of HIV prevention and treatment, it has become increasingly clear that gender identity and expression are critical considerations when designing and implementing sexual health programmes for key populations (Sevelius et al. 2016; Poteat, German and Flynn 2016). In Brazil, researchers have documented how gender identity intersects with access to health services, transition-related medical care and experiences of violence and discrimination (Pinto et al. 2017; Pelucio 2009; Carrara and Vianna 2006; Prado Cortez, Boer and Baltieri 2011). *Travesti*, for example, is a complex social and cultural subjectivity in Latin America, which prior to the turn of the twenty-first century was one of the only terms used in Brazil to indicate feminine

gender identity among persons assigned 'male' at birth (Kulick 1998). Those who identify as *travestis* experience high levels of social vulnerability and violence (Carrara and Vianna 2006; Prado Cortez, Boer and Baltieri 2011; Pelucio 2009) and are more likely to inject silicone than those who identify as *mulheres transexuais* (transsexual women) (Pinto et al. 2017), a term that along with *mulheres trans* (trans women) has become more commonly used over the past two decades. Researchers have also emphasised that identity categories in Brazil are fluid, the result of historical and political processes, and, as Pinto et al. (2017, 2) note, 'do not encapsulate the subjectivities and diversity of gender expression in this [trans] population'.[2]

The model of gender affirmation is a conceptual model developed in the social and political context of the USA that examines how unmet need for gender affirmation contributes to risk behaviour and diminished self-care (Sevelius 2013). Gender affirmation here refers to an interpersonal, interactive process whereby a person receives social recognition and support for their gender identity and expression. Meeting trans women's needs for gender affirmation, such as through gender-affirming relationships and support, may decrease risk behaviour and increase self-care (Sevelius and Johnson 2013; Colton Meier et al. 2011). Prevention programmes targeting gay and other men who have sex with men are not typically designed to address gender affirmation needs and transition-related health, often resulting in low enrolment and participation by trans women. Instead, trans women often express unique concerns about HIV prevention strategies, such as potential violence from partners when using the HIV self-test, or concerns about potential drug–drug interactions between pre-exposure prophylaxis (PrEP) and hormone therapy (Lippman et al. 2015; Sevelius et al. 2016).

Guided by the model of gender affirmation, in this study we explored how the social context of stigma and transphobia affects Brazilian trans women's access to health care and preferences for HIV prevention and care programming. Acknowledging the diverse subjectivities and identity categories of trans women in Brazil, we were particularly interested in identifying key elements to include in HIV-related intervention programmes that seek to reach a broad range of trans women while also addressing shared vulnerabilities, such as gender affirmation needs. We also sought to identify additional questions for future research to fully address the diverse and interwoven vulnerabilities that trans women face in leading safe, fulfilling and healthy lives.

Methods

A total of 36 (of 46 invited) trans women participated in six focus groups during the period of June–July 2015 at the Oswaldo Cruz Foundation (FIOCRUZ) in Rio de Janeiro. The focus groups were led by health professionals with experience working with trans communities, including a trans woman. Three focus groups were held with 21 trans women who were HIV-negative and three with 15 trans women who were living with HIV. Our recruitment approach was multi-pronged, including in-person recruitment at both community- and clinic-based events and telephone contacts from lists of participants who had previously given consent to be contacted at FIOCRUZ.

Informed consent was obtained from all individual participants included in the study. All focus groups were conducted in Portuguese by fluent and/or native Portuguese speakers. Incentives included lunch and travel. The focus group discussion guides were informed by the model of gender affirmation and explored access to HIV prevention among HIV-negative participants and HIV treatment and care among those living with HIV. Discussion of prevention approaches included both social-behavioural (antiretroviral medication adherence support, group- and/or individual-level risk reduction interventions, increasing access to social support groups and social empowerment) and biomedical strategies (PrEP, treatment as prevention [TasP], self-testing for HIV, e-health). Focus groups were recorded with participants' consent and transcribed with blind identifiers. In this paper, we use pseudonyms to attribute quotes to participants.

Initial coding of the focus group transcripts was conducted using Atlas.ti software, which permits thematic coding, annotation and visualisation of qualitative data (Muhr 2004). Analysis involved content analysis of the transcripts, identifying sections consistent with *a priori* themes based on the model of gender affirmation and the overarching goals of the research. These included codes for social identity, codes related to gender affirmation (e.g. access to gender affirmation, unmet need for gender affirmation), codes relevant to experienced and anticipated stigma around both gender identity (e.g. transphobia) and HIV (e.g. HIV-related stigma) and codes for each prevention or care strategy. Focus group transcripts were analysed through an iterative process in which emerging themes and new codes were included. After finalising codes, single codes were searched and compared across the data, in addition to overlap of multiple codes and code groups to identify patterns and associations between different analytical categories. Quotes were translated by a native English speaker fluent in Portuguese who conducted the analysis, and then back-translated to Portuguese by a native Portuguese speaker fluent in English to verify the translation. The study was approved by institutional review boards at both the University of California, San Francisco and FIOCRUZ.

Results

Participant characteristics

Participant demographics are listed in Table 1. All reported being assigned male sex at birth, and the majority were between the ages of 18 and 30 (42%). The majority of participants identified as either *travesti* (39%) or *transexual* (31%). In Brazil, race and ethnicity are commonly described in terms of categories of skin colour. In this study, 39% of participants reported being *branco* (white), 33% *preto* (Black) and 28% *pardo* (brown or mixed race). In terms of HIV status, 58% reported being HIV-negative, and 42% reported being HIV-positive.

Barriers to gender affirmation: transphobia and HIV-related stigma

Microaggressions such as being called by the wrong name, or the correct name but with disdain, were particularly common in participants' narratives of experiences in public health care services and were reported at all levels of service (from reception to medically qualified providers). Institutional settings, due to reliance on rigid gender

Table 1. Sociodemographic characteristics ($N = 46$).

Variable	N	%
Age		
18–30	15	42%
31–45	14	39%
46–60	7	19%
Sex at Birth		
Male	36	100%
Gender Identity		
Feminine	9	25%
Woman	2	6%
Transexual	11	31%
Travesti	14	39%
Sexual Orientation		
Bisexual	1	3%
Heterosexual	12	33%
Homosexual	18	50%
Other	5	14%
Skin Colour (cultural classification used in Brazil)		
White	14	39%
Black	12	33%
Brown	10	28%
Education		
Primary School (Complete)	14	39%
Primary School (Incomplete)	9	25%
High School	11	31%
College	2	6%
Income		
R$0	10	28%
R$300–R$900	11	31%
R$901–R$1500	13	36%
>R$1500	2	6%
HIV Status		
Positive	15	42%
Negative	21	58%

and sexuality categories, were ones in which HIV- and trans-related stigma and discrimination were layered and intertwined. Many participants described how service providers often associated transgender identity with HIV, and that any health problems they reported were assumed to be HIV-related.

> If we arrive in a public hospital now … If I arrive with a pain here … [the response is] to do an HIV test … Honestly, I always do the HIV test, I always have it on hand [to show health workers]. 'I did the test yesterday. I have pain, but I don't have HIV'. The prejudice is very large. (Ana, HIV-negative)

Participants' experiences with seeking health care were described as particularly frustrating when they were seeking care unrelated to HIV and were not offered other types of health care without making a specific request. Participants' fears of being associated with HIV and the related stigma were so strong that access to care was impeded.

> I know people, friends, *travestis* and *transexuais* that have this difficulty [going to the health clinic] … Sometimes, they are dying at home and they don't want to go to urgent care because [they think] 'they are going to associate me with HIV'. (Gabriela, HIV-positive)

An additional barrier to seeking care was not having one's social name respected, despite the fact that federal laws and decrees in Brazil mandate the use of social names in public health clinics and schools. For many, the idea of being called by their male birth name in public was enough to avoid going to the clinic.

> The first barrier that exists among us *travestis* and *transexuais* is the social name … You arrive sick at a hospital to do a CD4 [count] … and the nurse calls you by the name 'João' … So you don't go back for the next appointment. Instead you say, 'Shoot, I'm going to be called João again … I am very weak, I'm just going to stay here'. And you stay at home. A friend of mine died at home because of this. (Mariana, HIV-negative)

This disconnect between policy and practice in terms of the civil rights of trans people in Brazil was observed in all of the focus groups. There was a sense among participants that negative experiences such as these are inevitable, despite the fact that the civil and social rights of trans communities are recognised by the State. The following participant emphasises how civil and social rights are no guarantee against stigma and discrimination:

> *Travestis* and *transexuais* have civil and social rights, people say that they have these rights, but you see people don't respect *travestis* and *transexuais*. They are always going to discriminate. (Camila, HIV-positive)

Even when identity terms were respected, participants felt that it was not always in the spirit of support and sincerity: 'My issue is respect, understand? … It doesn't matter if you call me by a woman's name if it's going to be with a tone of debauchery, understand?' (Leticia, HIV-negative).

Violence limits prevention empowerment and HIV status disclosure

Even though the focus group discussion guide did not ask specifically about it, violence was recurrent in the narratives of trans women's private lives, especially in regard to partner reactions to discussion related to HIV. Participants described violent reactions to suggestions of HIV prevention methods, such as condoms, which often led to avoidance of sex and fearing intimate relationships in general:

> One time I went to have sex with a person and when I said that I would only have sex with condoms, he had an extremely aggressive attitude … he tried to physically hurt me … It was, like this, he kept me here and said, 'what are you thinking, *viado* [fag], that I am sick? It is you all who pass on diseases to others, not me, not me. I am married, I have my wife, I have my children'. This traumatised me so much that I spent three months without having sex with anyone, out of fear. (Juliana, HIV-negative)

In addition to violence, the quote highlights something of the stigma associated with trans identity and HIV, whereby married men with wives and children are seen as 'clean' and trans women are associated with 'disease'. Experiences such as these had strong repercussions for some participants in terms of avoiding sex and fearing violent reactions to suggesting HIV prevention methods and discussing HIV status with partners.

Fear of violence influenced decisions not to disclose HIV status to partners: 'I am not going to come up to someone, a friend who I don't know, who is outside my day-to-day and say, "Ah, I have HIV" … He is going to beat me' (Luiza, HIV-positive).

Perceptions of PrEP and the HIV self-test

Participants expressed the desire to avoid medical settings as much as possible due to enacted and anticipated stigma, and concerns about confidentiality. Biomedical prevention technologies such as PrEP, HIV self-testing (available in Brazil since 2015) and TasP were considered attractive options for protection beyond condom use and for increasing one's autonomy from medical settings.

Some participants were concerned that PrEP could make people feel invulnerable to HIV, like 'Popeye's Spinach' as one participant described it, potentially leading to an increase in unprotected sex and the onward transmission of HIV.

> Just like they don't know about the test, about prevention, they are not going to have a clue that, 'oh, if I take one I don't need the other' … They have to keep having the same information, because if they don't, they are going to think that PrEP is going to turn them into a steel plate of immunity … 'I can't get it, it doesn't matter, I am taking PrEP and that's it …' (Vitoria, HIV-negative)

Furthermore, some participants expressed distrust regarding PrEP's efficacy:

> My partner and I are part of the PrEP project, but even so, I don't trust it. I don't think that a pill is going to totally prevent [HIV]. I have other partners in my life. And him, I don't know. We don't have the virus, but … I don't know what he does in the street. Sometimes I have sex with someone who says they don't have it … But I always take it [PrEP] and also use condoms because I don't trust it [PrEP]. (Clara, HIV-negative)

Participants emphasised that while it was a priority to make PrEP widely available, it was equally important to ensure that it is distributed with accurate information:

> The question for me is not about where. For me, it [PrEP] could be distributed at the bakery, it is just that the problem is not distribution, the problem is the lack of information. (Juliana, HIV negative)

Lack of information about PrEP was seen as contributing to HIV-related stigma towards those who use it. One participant described how when others found out that she was taking it, they assumed that she was HIV-positive.

> Let's talk about PrEP … for as much as I had said that it was a treatment for pre-exposure, people called me, sent me Facebook messages, others more openly asked if I was sick. (Juliana, HIV-negative)

HIV-related stigma also influenced how participants perceived HIV self-testing. Few had heard of it, and while many thought it was interesting in terms of offering ease, privacy and autonomy especially in terms of being able to avoid the health clinic, they were concerned about people not being psychologically prepared for the results.

> Not everyone has a psychologist, not everyone has support … I am going to be sincere with you, I don't have the support to know if I have HIV or not, doctor. (Aline, HIV-negative)

> No one is emotionally prepared to do one of these HIV tests at home. I think that they should at least have … they should be sold like black-labelled medicine is sold, with a medical prescription. Because it is a very serious thing for you to go to the pharmacy like someone who is going to buy medicine for a headache medicine and include in your basket a self-test to know if I have HIV. (Leticia, HIV-negative)

Concerns were also expressed that the HIV self-test could be imposed on them by clients or partners and provoke a violent reaction should they test positive. The following participant saw risks from both her clients as a sex worker and her steady partner.

> I'm a sex worker and we're subject to a lot of risks, right? What if I get one of those types of guys, like has happened before, that puts a gun to my head and says, 'do the test now. If in 20 minutes it's positive, I'll kill you'. And now what do I do!? Then I am a seropositive *trans* and I didn't want to do the test, but I had to because there was a gun to my head and they found out that I am [HIV positive], they kill me, and it's over … I wouldn't do it alone, and I would only do it in front of him [boyfriend] if he made me. Because if it is positive, he is going to want to kill me! (Clara, HIV-negative)

These concerns were primarily related to the test being used in a situation that could potentially lead a person to feeling depressed or experiencing violence. A key theme was that the decision to use the HIV self-test should be the person's own and should be conducted in a supportive situation where they would be prepared for the result. A few participants felt that it was important to respect a person's privacy and to regard one's decision to request the test as a sign that the person is ready to take it.

> You have to think that if the person is going to go to a pharmacy and buy a test to do at home it is because she wants to know and doesn't want to seek out a professional; she wants to keep it to herself. (Leticia, HIV-negative)

In a similar vein, another participant commented that being able to avoid therapists and the fear that they often provoke in people regarding HIV could be liberating:

> I am in favour of having the test in any pharmacy, I am 100% in favour of it. Why? Because sometimes there really is a psychological terror that comes from psychologists and psychiatrists … Because he is trying to show us the risk that we are running, and for us to avoid it … It's a drag. The first time that I did an HIV test in my life I almost peed my pants. Perhaps just going to the pharmacy would liberate one from the psychological terror that they feel. Of course, if you want to kill yourself, if you discover it at the medical clinic or in the pharmacy, you are going to kill yourself either way. (Ana, HIV-negative)

Access to gender affirmation: social and behavioural intervention programming

The perceived positive aspects of biomedical technologies such as increasing autonomy from public health services and providing additional protection were also reflected in participants' interest in social interventions that would build peer support and solidarity networks. Participants suggested that programming should have both trans-specific and more general activities, including covering topics beyond HIV.

> It [group level interventions] would work if it had a little something more … We *travestis* and *transexuais* need more … because I don't make a living just by going to meetings, just snacks and Coca-Cola. Outside of here I am the one who knows about my life. I have to do things myself. So, I don't present myself as a victim, I am not a victim at all! But I think the way you [facilitator] talk about the activities is perfect, it is just that it has to have a little more. And then when this activity is over, when this meeting is over, we go back to the street? (Mariana, HIV-negative)

Increasing autonomy included the desire for groups to go beyond being safe spaces for discussion to offering concrete skills. As the above participant mentions, the meetings are not perceived as being enough to change their circumstances outside of the group space. It was important to many that group spaces recognise the structural barriers that were described as more central to trans women's well-being than HIV.

> To respond to your question, the *travestis* and *transexuais* there where I live don't like to talk about HIV, they don't like to talk about the HIV test, they don't like to talk about any of that. They barely talk about condoms … generally [we talk about] topics of militancy, professional disillusion, etc. … these types of things … But to talk about STDs in general, the girls, many of the girls that I know don't talk about it, they don't like it … They don't like to participate in conversations and they don't let you insist. (Juliana, HIV-negative)

The majority of participants emphasised that support groups and empowerment-based group interventions should be open both in terms of serostatus and gender identity. Some participants felt that separating groups by serostatus would reduce HIV stigma, whereas others felt it was important to have mixed groups to avoid highlighting differences and identifying who was positive and who was not. As Gabriela stated, 'if you separated meetings for HIV-positive and HIV-negative, [people will say], "look, the positives are leaving the room", I don't think that's cool' (Gabriela, HIV-positive). Overall, the sense was that serostatus-inclusive groups were preferred. As one participant shared, 'Having something mixed would be good to open up people's minds' (Cristina, HIV-positive).

In terms of gender identity, the discussions revealed that many participants thought of themselves and their own identities as fluid, largely depending on the context and who was defining the categories. For some, the term *travesti* held negative connotations and associations, and they preferred the words *trans* or *transexual* which were associated with desire for a more 'respectable' identity term and subjectivity. For others, using the term *travesti* was source of pride and a political decision to fight the stigma associated with the term. Perceived connections between identity and sexual risk behaviour, such as assumptions about *travesti* identity and engagement in sex work, were recurrent themes throughout the focus groups. These perceived connections are critical to consider in terms of trans-specific information networks and HIV programming and intervention planning.

Importance of trans-specific information networks

Participants trusted information more when it came from other trans women than from health care providers, and for this reason they valued peer educators and saw having peers in the family clinics near their homes as crucial to successful prevention and treatment. Services that employed trans women were seen as more desirable because, as one participant stated, 'I feel more at home' Juliana, HIV-negative. Even if other non-trans staff members were welcoming and supportive, this was not perceived as equal to having a peer:

> I came here to FIOCRUZ because there is a *trans* person [*uma pessoa trans*] who knows how to talk like me, like all of us, she speaks the same language and makes us feel considered, we feel welcome thanks to her. The other boys here are cool, but they aren't the same as us. (Ana, HIV negative)

Participants living with HIV in particular emphasised the importance of having a trans staff person in the family clinic close to their homes.

> It'd be a dream, imagine? Let's say that a *travesti* lives in Penha and tomorrow, for whatever motive gets infected … Then she goes to the nearest health post, and there is someone there, a well-trained *travesti* that was trained for this [purpose] and will understand me. (Camila, HIV-positive)

Some of the participants worked as peer educators and shared their experiences from doing outreach work.

> Last week I went to hand out condoms at [place] and a *bicha* [slang for gay men and trans women] said, 'Oh, I want so much to do it [get tested for HIV], but I am so afraid' and then another one got into our conversation and started to say that she had HIV. 'I have it and I need to take care of myself', then I said, 'shoot, I've had HIV since I was 18, I've had the virus for 42 years'. She said, 'you're lying! Really?' and I said, 'Yes'. She said, 'What do I need to do to be tested?' and then I invited her. (Lorena, HIV-positive)

At the same time, the strength of community ties and sharing of experiences across networks can result in one negative experience affecting many people. In the following quote, a participant mentioned how she decided not to identify openly as a trans woman at a hepatitis C and HIV testing campaign after perceiving that a campaign volunteer had laughed and poked fun at another *travesti* ahead of her.

> I saw someone who looked like a *travesti*. I kept observing her, and when it was time for her to be tested, the volunteer poked someone else and laughed. I observed from far away and was like, 'Ah, I am going to be tested, should I say that I am a *trans* woman [*uma mulher trans*] or should I stay quiet and be tested?' I arrived [at the reception desk] … feminine sex. The girl didn't question anything … I could have said, 'I am a *trans* woman [*uma mulher trans*]', but since she had joked before, with the other girl, that didn't make me feel comfortable. (Paola, HIV-negative)

These interactions, and the subsequent sharing of personal stories, may hold more weight than any campaign or training provided by health clinics, as it is primarily from personal experiences and the stories of others that participants' perceptions of health services and HIV were formed. Social networks and the support of peers are highly valued in HIV programming, and health professionals should be cognisant of the far-reaching effects of stigmatising and discriminatory treatment they may enact towards trans women.

Discussion

This study sought to identify optimal elements of HIV programming for trans women in Brazil from the perspective of lived experiences of trans women, those living with HIV and those who are not, through the lens of the model of gender affirmation. Our findings include important insights from trans women's experiences in the public health system that may be leveraged to expand access to and improve the quality of

health care for trans women in Brazil. Participants provided input on both biological and behavioural prevention strategies as well as a variety of programmatic and conceptual frameworks for intervention design. Participants emphasised the importance of a gender-affirming, combination prevention approach that promotes a balance of autonomy, reaffirms the importance of peer support and solidarity, moves beyond an HIV-only vision of health and addresses systemic stigma, discrimination and violence in public health services and their home communities.

In describing ideal intervention designs, trans women described two interrelated considerations: the need to avoid stigma, violence and discrimination, and the desire for gender-affirming and empowering services, preferably delivered by peers. Addressing unmet need for gender affirmation among trans women in the context of HIV prevention can help to address the medical mistrust that stems from previous experiences of microaggression and transphobia when seeking medical care. Furthermore, increasing trust by using peer staff in the delivery of such interventions is also likely to increase participation, the motivation for self-care and empowerment through modelling employment options for trans women.

Biomedical technologies such as PrEP and HIV self-testing, while viewed with scepticism by some, were generally regarded as important developments in increasing the autonomy of trans women in having control over their own HIV prevention strategies and knowledge of their own status. The avoidance of public health systems is a strategy widely used by trans women to protect themselves in the immediate sense. However, public health care systems must be held accountable to their mandate to improve their ability to serve trans women in an affirming and respectful manner. Furthermore, in designing future combination prevention approaches for trans women in Brazil, it is important to attend to differences and affirm participants' identities by using terminologies that they are comfortable with. While participants did not necessarily always agree on what could be assumed about a person based on their identity as a *travesti*, *trans* or *transexual* woman, it was clear that these terms were very important in both a personal sense and in community interactions. The nuances and weight of these identities must be attended to when designing HIV programming for trans women in Brazil.

In Brazil, and in similar settings where universal health care is available at no charge, researchers have called attention to the importance of addressing stigma and discrimination within a vulnerability and human rights framework in order to reduce the most severe health disparities experienced by the most vulnerable populations (Paiva, Ayres and Buchalla 2012). Our findings revealed that while Brazil has progressive public policies to protect trans civil rights, participants experienced pervasive stigma and discrimination, indicating that their lived experiences do not reflect these protections. Even the most basic principles of Brazil's universal health care system, such as equity and access, have been difficult to guarantee on a broad scale. The nationwide evaluation of the country's *Centros de Testagem e Aconselhamento* (TAS) (counselling and testing services) conducted by the Ministry of Health found that access to services was especially low among the most vulnerable groups and that the TAS did not prioritise reaching these groups (Grangeiro and Ferraz 2008). Thus, trans people and other vulnerable groups have demonstrated particular difficulty accessing HIV counselling and testing.

Of particular concern is the current political and economic crisis in Brazil whereby the public health system is under threat. A Constitutional Amendment was passed in 2016 that froze the already underfunded health and education budgets for 20 years. Issues such as shortage of personnel, lack of adequate training and stockouts of drugs and supplies have made Brazilian AIDS policies particularly difficult to implement with vulnerable groups (da Fonseca and Bastos 2017). Additionally, there has been an increase in conservatism in Brazil that has been associated with the censorship of HIV prevention campaigns and sexual education materials (Malta and Beyrer 2013; Paiva and Silva 2015). This situation has led some researchers and activist groups to publicly denounce what they see as a shift away from human rights approaches that historically informed the Brazilian HIV response (Malta and Beyrer 2013; Seffner and Parker 2016; Paiva and Silva 2015; Scheffer and Rosenthan 2014). We hypothesise that if access to the *Sistema Único de Saúde* (SUS; or single health system, Brazil's public health care system) is hampered by ongoing discrimination in the context of shrinking resources and moral conservatism, the barriers to health care currently experienced by trans women in Brazil will increase.

Limitations

While our study sample was diverse in terms of age, gender identity, sexual orientation, skin colour, education and income, the following limitations should be considered when interpreting our findings. The sample size was too small to permit meaningful comparisons or stratification along demographic dimensions; however, the diversity of participants helped to ensure a rich dialogue that included a variety of perspectives. Length of time since transition was not measured, as this construct can be difficult to operationalise; thus, it is possible that trans women may have different experiences with health care based on transition status. Our sample was drawn from a primarily urban population in Rio do Janeiro and may not generalise to less urban areas of Brazil. While focus group facilitators were health professionals (including a trans woman) with extensive experience conducting qualitative research and working with trans women, it is possible that their professional status may have influenced the willingness of the participants to discuss certain barriers to health care.

Conclusion

To ensure universal and safe access to care for trans people, future programmes and interventions must address structural issues (e.g. stigma, gender affirmation, employment, violence) not as complementary to other components, but as central to trans women's ability to survive. Our data strongly support a gender-affirming approach to trans health, in which HIV programming for trans women is not limited to individual and biomedical strategies such as greater PrEP uptake or higher HIV testing rates but affirms the diverse subjectivities of trans women and supports their autonomy as they cultivate health and empowerment both for themselves and their communities.

Notes

1. To respect the diversity of terms in Brazil and the discussions within the international literature (Dourado et al. 2016), in this paper we use the umbrella term 'trans women' in English to refer to people assigned 'male' at birth who identify as female, transgender or transsexual. Throughout the paper we retain the original terms in Portuguese used by participants to describe their gender identities (in italics).
2. An in-depth discussion of US trans identities in Brazil is beyond the scope of this article; we direct the reader to Kulick (1998) and Garcia (2009).

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